

# ELECTRONIC FUNDS TRANSFER (EFT) FORM

ND DEPARTMENT OF HUMAN SERVICES/MEDICAL SERVICES  
SFN 661 (04-03)

**PRIVACY STATEMENT:** The Privacy Act of 1974 (P.L. 93-579, Section 7) requires that the following information be provided when individuals are requested to disclose their social security number. Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a \$50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

The Department of Human Services has the capability of automatic direct deposit of payments. If you are interested in utilizing this service, we will need additional information to assist in providing you with a prompt, accurate payment. An authorization for direct deposit and a W9 are needed.

Please fill this form out accurately and completely, attach a voided check, deposit slip, or a document from your financial institution that verifies both your routing and account number. Please send this along with a W9 form and return to the address below. If you have questions regarding your account number or bank routing number, call your bank for that information.

Once you have been enrolled for electronic transfer of funds you will not receive a check or deposit slip with the Remittance Advice (R/A). Please inform your bookkeeping personnel of this to avoid unnecessary telephone calls to the department. The acronym "ACH" will appear in place of the check number in the upper left hand corner of the R/A indicating an automatic check deposit.

If you have questions or need more information, contact Provider Enrollment at (701) 328-4033 or 1-800-755-2604 or Email: [dhsenrollment@state.nd.us](mailto:dhsenrollment@state.nd.us)

→ Staple voided check, deposit slip, or document here ←	I authorize THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES and the financial institution named below to initiate deposits to the checking account listed below. This authority will remain in effect until I notify the department in writing to cancel it allowing the financial institution a reasonable opportunity to act on the cancellation.			
	Name of Financial Institution			
	Address of Financial Institution		City	State      Zip
	Provider Name		Telephone No.	
	Provider Address		City	State      Zip
	Signature			
	<b>NAME – PLEASE PRINT</b>			
	<input type="checkbox"/> Checking or <input type="checkbox"/> Savings Account Number: (You <b>must</b> check one)		Financial Institutions Routing Number:	
	EIN/SSN:		Medicaid Provider Number:	
	Return to: <b>DHS MEDICAL SERVICES – PROVIDER ENROLLMENT</b> <b>600 E. BOULEVARD AVE – DEPT 325</b> <b>BISMARCK, ND 58505-0261</b>			